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Nursing, Convalescent, and Rest Homes in California

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We are fast becoming an aging population. As our population becomes older, we may likewise expect a corresponding increase in the incidence of chronic disease.

Aware that these anticipated increases will tax our hospital facilities, the Bureau of Hospitals has made a study of nursing, convalescent, and rest homes to determine the status of those existing in California today as well as to evaluate the progress made in this type of hospital facility since the California Hospital Licensing Act went into effect in 1946. While nursing, convalescent, or rest homes are not for aged persons exclusively, most of the patients found in these homes are in the upper age bracket, and most homes are designed to accommodate the elderly patient.

Because the State Department of Public Health in California has no licensing jurisdiction over county hospitals, county facilities providing convalescent or chronic care have not been included in this report. Facilities usually referred to as "boarding homes for the aged" are not included because the regulating agency for this group of facilities is the State Department of Social Welfare. Such homes primarily provide only board and room and are not intended to provide medical or nursing service.

Hospital Licensing Act

The Hospital Licensing Act, passed in 1945, authorized the State Department of Public Health to license most types of hospitals. By this act, nursing, convalescent, and rest homes were included and named as one category of hospital, subject to regulations set up by this act.

The California Administrative Code,[1] which contains regulations adopted by the State Board of Public Health, states that "A nursing, convalescent, or rest home is any place or institution which makes provision for bed care, or for chronic or convalescent care, for two (2) or more patients, exclusive of relatives, who by reason of illness or physical infirmity, are unable to properly care for themselves. Alcoholics, drug addicts, persons with mental diseases, and persons with communicable diseases, including contagious tuberculosis, shall not be admitted or cared for in nursing, convalescent, or rest homes."

In 1946, when the Hospital Licensing Act in California went into effect, all hospitals covered by the act, including nursing, convalescent, and rest homes, were blanketed in and granted licenses upon the submission of applications. Facilities thus automatically licensed obviously included many which did not meet the minimum requirements set by the State Department of Public Health. The Bureau of Hospitals, which is administratively responsible for the licensing program, has assumed the task of bringing these facilities up to the minimum requirements. Specific deficiencies which most often existed included unqualified operators, unacceptable physical facilities, lack of patient and personnel safety (particularly fire safety), inadequate personnel, and inferior quality of patient care. Progress made in the improvement of these deficiencies is elaborated on later in this report.

Most of the nursing homes licensed by the State Department of Public Health are operated for profit. A few are operated by religious groups on a nonprofit basis and a few are operated in connection with existing general hospitals.

[1] Title 17, Chapter 3, Group 2, Subgroup 1, Section 235.

Types of Care

California's nursing homes provide a variety of care, including custodial or boarding home care, convalescent care, care of the aged, and care for the chronically ill. The services required in these homes vary greatly with the type of patient, ranging from minimal help for an ambulant aged person to constant and continuous nursing care for patients truly bedridden because of chronic disease.

In this report, the term "nursing home" will be used when referring to the type of facility which is licensed by the California State Department of Public Health as a nursing, convalescent, or rest home. Information for this study has for the most part been secured from files of the Bureau of Hospitals.

Present Nursing Homes

On July 1, 1951, 451 licensed nursing homes were in operation in California, totaling 8,706 beds. These are located in 35 counties, and for the most part, in concentrated population areas. Twenty-three counties had no licensed nursing homes at all, and eight others had but one such licensed facility. The following table shows the geographical location of these licensed nursing homes by county, also the number of beds found in each county.

Table No. 1. Location of Licensed Nursing Homes by County—July 1, 1951

County	*Number of nursing homes*	*Number of beds*
Alameda	59	866
Butte	6	65
Contra Costa	10	149
Fresno	11	219
Humboldt	2	83
Imperial	1	24
Kern	2	46
Lake	1	10
Los Angeles	160	4,286
Marin	5	83
Merced	1	6
Monterey	3	35
Napa	4	38
Nevada	1	6
Orange	10	215
Placer	1	6
Riverside	5	115
Sacramento	11	164
San Bernardino	10	172
San Diego	23	511
San Francisco	30	241
San Joaquin	6	100
San Luis Obispo	2	52
San Mateo	11	327
Santa Barbara	7	92
Santa Clara	30	420
Santa Cruz	9	134
Solano	2	16
Sonoma	11	83
Stanislaus	6	43
Sutter	1	3
Tehama	1	6
Tulare	3	20
Ventura	4	42
Yolo	1	34
Totals	451	8,706

Size of the licensed nursing homes, shows wide variation. (Table 2.) There are few large nursing homes in California. The average facility accommodates 19 patients. The study shows that many small nursing homes exist, some with only one bed and many with less than 10 beds. Only two nursing homes have accommodations for more than 100 patients.

Table No. 2. Range in Capacity of Nursing, Convalescent, and Rest Homes—July 1, 1951

Size	*Number of nursing homes*	*Total beds*
1- 10 beds	197	1,241
11- 25 beds	132	2,300
26- 50 beds	98	3,342
51-100 beds	22	1,455
Over 100 beds	2	359
Totals	451	8,706

Table 2 reveals that 43.7 percent of all facilities have bed capacities of 10 or less, representing only 14.3 percent of the total beds.

Discontinued Facilities

The first year of licensure, 1946, brought 462 nursing homes under the Hospital Licensing Act. This number is greater than the number licensed on July 1, 1951, but the bed capacity in 1946 was less than the bed capacity in 1951. The number of beds actually licensed changes from day to day in this category of hospital. New facilities begin operation, others discontinue. Some change capacity by converting existing space into additional patient areas. Some add beds through new construction of wings, etc., while other facilities have reduced the patient areas of existing space.

The following table shows changes in the number of facilities from year to year since the Licensing Act became effective.

Table No. 3. Number of Nursing, Convalescent, and Rest Homes Licenses Issued and Canceled, by Year, 1946-1951

Year	*Initial license issued*	*Facilities discontinued*	*Total licensed*
1946	462	55	462
1947	8	36	415
1948	18	43	407
1949	45	15	409
1950	60	24	494
1951 (to July 1)	26	6	457

In the past three years of the licensure program there appears to be a trend toward more new facilities beginning operation. Fewer have discontinued operation. The reasons for the great number of early terminations of nursing homes are not hard to understand. When the licensing program went into effect, many nursing homes had not clearly defined their services. Some of these facilities were accepting several types of patients, not all of whom were eligible for nursing home care. Such homes were granted nursing home licenses but later transferred to some other, official

agency for regulation. Others closed when the minimum requirements were established and the operators became aware that such requirements could not be met.

Of the 179 facilities which have discontinued their licensure as nursing homes since 1946, 121 actually discontinued operation. The reasons for closing, listing in order of frequency, are as follows:

1. Failure to secure fire clearance (lack of fire safety)
2. Failure to meet minimum requirements
3. Sale of, or loss of lease of property
4. Violation of local ordinances, particularly zoning
5. Poor health of operator
6. Death of operator

More than 50 percent of the homes that closed had capacities of six beds or less.

The 58 facilities which terminated licensure as nursing homes continued operation in another category of institution, as follows:

Homes for the aged	36
Department of Mental Hygiene	12
General hospitals	3
Establishment for handicapped persons	2
Department of Education	1
Tuberculosis nursing home	1
Maternity nursing home	1
Foster home	1
Specialized hospital	1

Fire Safety

The problem of fire safety has been paramount in the hospital licensing program. When the nursing homes were granted their initial license fire clearance by the State Fire Marshal was not required. The records show that of the 179 nursing homes that discontinued operation 52 had been granted fire safety clearance and 98 had been denied fire safety clearance. The remaining 29 had apparently ceased operation as a nursing home before fire inspections were made.

In contrast, all of the 158 new facilities which have begun operation since 1946 have been granted fire clearance by the State Fire Marshal.

Bed Capacity

Of the 158 nursing homes whose first license was issued after 1946, 64 percent of that group have a capacity of six beds or less. Only four of the 158 establishments have a capacity of 50 beds or more.

Characteristics of Present Nursing Homes

As has already been stated, 451 nursing, convalescent and rest homes were licensed by the State Department of Public Health as of July 1, 1951, with a total capacity of 8,706 beds.

Personnel

Administratively, 250 of the 451 nursing homes are operated by the "practical nurse." For our purposes here, a practical nurse is a person who has had some experience in the actual care of patients, and may or may not have had some formal training in some type of nursing. For the most part, they operate the smaller facilities.

The study shows that 119 of the nursing homes are operated by graduate nurses. These nurses have had formal training, have graduated from a school of nursing, but may or may not be registered as registered nurses in California. Many of these persons are themselves in the older-age group and are operating such facilities in their own homes. Fifty-seven facilities are operated by lay administrators and 23 by physicians.

Turning to the staffing practices, 279 of the 451 nursing homes have graduate nurses on their staffs, while 172 do not. A total of 617 graduate nurses are employed in the 279 facilities.

Sixty-five percent of all the graduate nurses are employed in the nursing homes with bed capacities ranging from 11 to 50 beds, which represents about 65 percent of the total beds.

This count indicates that the graduate nurses are pretty well distributed throughout the institutions. It would not necessarily signify that the smaller nursing homes are less expertly staffed than the larger ones. However, it must be recognized that in many of the small nursing homes the nurse, whether she is the operator or not, is not devoting her total working time to actual patient care. She may be assisting with the administration, cooking, cleaning, laundry, and with other tasks, ordinarily not done by the nurse in the larger facility.

Our study has not been able to evaluate the extent of these activities. While a graduate nurse may or may not be considered preferable to a practical nurse in staffing a nursing home, her presence as a member of the nursing staff is a criterion which carries some weight in evaluating a nursing home facility.

The practical nurses in all facilities number 1,713, while there are a total of only 617 graduate nurses. This ratio is less than 3 to 1 and is undoubtedly affected by the present general shortages of graduate nurses. Because our study makes no attempt to determine percent occupancy of these facilities, it is not possible to determine the amount of patient care actually being rendered; however, there is one person providing nursing care for every 3.7 beds in these facilities. While all these persons are giving some nursing care, it must again be taken into account that some of them are performing other duties than nursing in some of the institutions.

Physical Facilities

Nursing homes are housed in many types of buildings. Some, particularly the smaller ones, are the "family dwelling" type in which the operator and her family live, with only a few rooms designated for patients. In some of the multistory buildings, the family lives on the second floor with the first floor devoted to patient area. Some of the larger ones are the old fashionable type mansions, expansive in style and made to conform to nursing home needs as much as possible. A few are institutional in character of construction, having been built as hospitals, old folks homes, orphanages, or as nursing homes. It is encouraging to note that during the past two years a few have been designed and built to operate as nursing homes. These have been built according to the requirements set by the State Department of Public Health, in accordance with state and local building codes, and in conformity with requirements of the State Fire Marshal.

Four hundred and twenty-two of the nursing homes are built of stucco, frame, or a combination of frame and stucco construction. Only 29 nursing homes are built of brick, concrete, cement block, or other substances which can be considered to be of fire resistant material. This is due to the fact that so few of these facilities were actually built for the purpose of housing and caring for some type of patient.

About 50 percent of the nursing homes are one-story structures. It is much easier to make a one-story building conform to fire safety standards for a nursing home than a multistory structure. Consequently, when prospective operators select a building for a nursing home, they will usually select a single-story building.

Some nursing homes are not confined to one building but utilize multiple buildings for patients on the same property. This represents new construction in only a few cases. More often, in order to increase bed capacity, a nearby garage, guest house, some other building on the same property, or even a house next door, has been converted into patient area. The disadvantages of such an arrangement are many, and are generally regarded unfavorably by the State Department of Public Health. Nevertheless, some such facilities were licensed and continue to be licensed under the program. At the present time 81 homes are operating with this physical arrangement. These facilities usually encounter difficulties of staffing, food service, heating, supervision, and control.

Because most of the nursing homes are located in concentrated population areas, all but 4 percent use municipal water supplies. However, 25 percent do maintain their own sewage disposal systems. In most cases, these are nursing homes located in rural areas or in outlying districts of the larger cities.

Some evidence of the instability of this category of hospitals is shown by the fact that 122 of the existing nursing homes have changed ownership at least once since first being licensed, and some as many as four times.

Fire Safety

The importance of fire safety cannot be overestimated and this subject has played an important role in the California licensure of nursing homes. Since 1946, initial fire clearance is required before the State Department of Public Health issues its license. Facilities are gradually being cleared, to the extent that on July 1, 1951, 433 nursing homes had been granted fire clearance. The 18 remaining without clearance are improving their fire safety and this number will be reduced rapidly, until all nursing homes will be declared to be reasonably safe, according to regulations set by the State Fire Marshal. There are instances when fire clearance is denied on annual inspection even though the nursing home has received previous fire clearance. This is an assurance that nursing homes will continue to be reasonably safe. That a large percentage of these facilities have fire safety clearance can be considered a real accomplishment and a credit to the agency responsible for fire safety in California. This is particularly true when it is realized that many of the present nursing homes are old converted residences, which if not made to conform to fire safety standards would certainly not offer any degree of fire safety to their occupants.

Present Deficiencies

In reviewing the progress made since the licensure program came into existence, major deficiencies which still persist have been noted. Many of the earlier deficiencies have been overcome. In some instances, nursing homes have been forced to discontinue as such by inability to overcome the obstacles to licensure. In others, extensive physical alterations enabled them to meet requirements. Installations of additional equipment have also improved the homes. As a result, the problems recognized made by the Department of Public Health in this field are no longer of the same magnitude as a few years ago. Present department recommendations include less major deficiencies, are more detailed in character, and, while affecting patient care, are not likely to change the basic character of the institution.

Recommendations relating to safety and welfare of both patient and personnel figured heavily in the early stages of the program. Repairs of certain areas, improvement of working and service areas, improvement of heating, ventilating and lighting facilities, betterment of patient accommodations, and other items per-

taining to safety and well-being of the patient were required of licensed facilities in the years that followed the introduction of the licensing program.

The subject of food service has come into the picture frequently. Many nursing homes, operating very much as private homes, were not in position to provide food service as set up in the minimum requirements for nursing homes established by the State Department of Public Health. In many instances, the dishwashing technic was substandard. Since disinfection by physical means is required by regulation, additional equipment is usually necessary to attain the required temperature. Refrigeration is not always adequate to care for foods which require low temperatures. Proper food storage areas and dish storage areas are not always satisfactory from the standpoint of adequacy, cleanliness or location. The study shows that 72 nursing homes are still not meeting all minimum standards for food service.

Another problem is that of cleaning and disinfecting bedpans. Improvement usually necessitates the installation of additional equipment. Ninety-one nursing homes are operating without an approved technique in this respect.

The subject of patients' records requires consideration because almost one-half of the nursing homes show defects in one or more phases of the patient's record. It is generally accepted that good patient records are essential tools in the administration of good patient care in any type of hospital facility. Because nursing homes, according to the law, are one category of hospitals, patients' records must be kept, are regarded as legal documents, and may be produced in court under subpena. Incompleteness and inadequacy are the most common deficiencies noted. Nursing home operators often fail to realize the importance of good patient records, due partly to the fact that the role of nursing homes as hospitals is not well established, and partly to the inexperience and lack of knowledge regarding records. In some facilities, there are persons who are administering patient care who do not know what constitutes adequate patient records. Many omissions are made which have a direct bearing on patient care. Difficulty on the part of the operator is sometimes encountered in impressing the physician with the importance of his part in the patient's record as regards written orders, progress notes and a written diagnosis. In some cases, the operator fails to get pertinent information concerning the patient. All these contribute to the deficiencies of patients' records.

Deficiencies relating to medications, their administration and their safe storage, have been, and still are, fairly common.

In a few nursing homes it is found, upon inspection by the Bureau of Hospitals, that more patients are being housed than the number for which the home is licensed. Other nursing homes are found to be caring for a type of patient for which they are not licensed. The most usual abuse of this regulation of the presence of mental patients, alcoholics, or drug addicts. This type of patient should be cared for in facilities regulated by the State Department of Mental Hygiene.

Maintenance can be considered poor in a few cases, but it can be said that most facilities are in a state of good repair. Evidences of poor housekeeping, uncleanliness, and unsanitary conditions are seen in a few institutions.

Insufficient personnel is evidenced by apparent inadequacy of patient care in some facilities. While it is hard to determine what constitutes an adequate staff, and while all facilities vary in their staffing patterns, there are certain criteria which can be used to evaluate patient care.

Future Possibilities

In conclusion, it can be said that this report has evaluated to some extent the licensure program conducted by the State Department of Public Health in the regulation of nursing homes. Little or no attempt has been made to gauge the *quality* of service which is being rendered by the nursing home facilities. It is true in California, as in most other states, that emphasis by the licensing agency thus far has been placed on safety, sanitation of environment, and the provision of basic needs for adequate patient care.

Indirectly, the report goes further than evaluating accomplishments and noting shortcomings. It gives some indication of the direction in which future efforts will probably be exerted. Recognizing nursing homes as one type of hospital facility, future activities of the licensing agency might be directed toward further developing and improving the quality of services of these establishments. This will not be accomplished by further establishing requirements and inspecting facilities for their fulfillment. It will come through staff education, intensive supervision, through various education projects such as institutes, workshops, publications, etc., and through consultative and advisory services on the part of the licensing agency. As nursing homes become better established units within a community, they will come to play an essential role in a complete patient-care plan.

It is hoped that they will be prepared to render services based on the total needs of their patients—with staff and equipment to rehabilitate them physically and mentally. They will thus provide the care and treatment which modern science advocates in this day of increased longevity, for the physical disabilities which accompany old age.

Reporting of Handicapped Children

Because of a recent revision by the State Board of Health of the Minimum Standards for the Care of Physically Handicapped Children (Administrative Code, Title 17, Public Health, Section 2900) physicians, health and welfare agencies are no longer required to report all handicapped persons under 21 to the State Department of Public Health. Rather, as a part of a county's active and continuous program of case finding, physicians and agencies should refer all cases in need of crippled children services to the local agency within the county which is administratively responsible for the program. In most counties the health department has this responsibility, while in other counties the county welfare department is administratively responsible.

Children's Bureau Grants Funds for Hearing Center

Special funds to assist in the establishment of a hearing center in Southern California have been granted to the State Department of Public Health by the U. S. Children's Bureau. An initial grant of $10,000 has been made for this work. The center is being planned for the Children's Hospital of Los Angeles. An announcement will be made later as to when the new services will be instituted.

No unified center now exists in California to which a child with impairment of speech or hearing can be referred for complete evaluation and specialized definitive treatment. Under the new program such an evaluation will cover medical (including psychometric and psychiatric), otological, hearing and speech factors in each child's case. Treatment needs will be assessed with respect to surgery, medical care, and rehabilitation—including auditory training, speech therapy, counseling and guidance. Attention will be given to the training of personnel to staff the center.

Laboratory Courses

From time to time the State Department of Public Health receives information on the dates and content of short training courses offered by the U. S. Public Health Service in the bacteriological, chemical, and other laboratory aspects of environmental sanitation. Such courses are generally given at the Environmental Health Center of the U. S. Public Health Service, which is located in Cincinnati, Ohio. Information on these training courses may be obtained from the Division of Laboratories, California State Department of Public Health, 2180 Milvia Street, Berkeley.

Supplemental Federal Funds Granted for California Programs

Relapse of funds from the various states has made possible the reallocation of $51,834.33 to the California State Department of Public Health by the U. S. Public Health Service for designated use in the venereal disease, tuberculosis, general health, heart disease and cancer program categories. The supplemental grants available to California this year are less than those of the 1950-1951 Fiscal Year by $18,469.43.

Below are the amounts and designated use of the supplemental grants made this year and last:

	Fiscal year 1950-51	*Fiscal year 1951-52*	*Amount of decrease*
Venereal disease	$10,031.91	$5,490.21	—$4,541.70
Tuberculosis	7,182.97	7,156.79	—26.18
General health	18,284.89	10,259.13	—8,025.76
Heart disease	17,735.71	14,230.62	—3,505.09
Cancer	17,068.28	14,697.58	—2,370.70
Totals	$70,303.76	$51,834.33	—$18,469.43

Including the supplemental grants, total federal funds allocated in the above categories for the two fiscal years are as follows:

	Fiscal year 1950-51	*Fiscal year 1951-52*	*Decrease*
Venereal disease	$215,131.91	$135,490.21	—$79.641.70
Tuberculosis	318,682.97	303,056.79	—15,626.18
General health	680,784.89	653,059.13	—27,725.76
Heart disease	89,435.71	73,030.62	—16,405.09
Cancer	193,268.28	185,097.58	—8,170.70
Totals	$1,497,303.76	$1,349,734.33	—$147,569.43

Diabetes Teaching Kit Available

A complete kit of instruction materials for teaching diabetic patients has been developed by the Public Health Service in cooperation with the American Diabetic Association and the American Dietetic Association. It can be borrowed from the State Department of Public Health through the Bureau of Health Education or purchased from Health Publications, Inc., 216 N. Dawson Street, Raleigh, North Carolina. The purchase price is $49.80.

The kit consists of 11 units of instruction and is designed for the group instruction of diabetics by a qualified instructor. There is a color filmstrip and accompanying record for each unit of instruction, together with wall charts reproducing in color salient teaching points from the filmstrips. There is also a 60-page instructor's guide. Sample copies of materials to be used by the patients are also included, but the necessary quantities have to be purchased from Health Publications Institute.

San Diego Chiropractor Sentenced in "Cancer Cure" Fraud

Long under investigation, a vicious fraud which victimized cancer patients was stopped and penalized this month when a San Diego chiropractor was sentenced to one year in the San Diego County Industrial Road Camp, plus nine years' probation.

Two years ago a woman in the San Diego area died of chemical burns caused by a "cancer ointment" bought from a "fly-by-night" salesman who was, it appeared, one of several sources of supply. This death evidently warned the promoters to lie low, but several months later the cancer salve again made its appearance when the chiropractor, a Dr. J. O. Ryan, was reported attempting to sell it for prices ranging from $200 to $600.

Dr. Ryan was then given the opportunity to attempt a sale under circumstances arranged through joint cooperation of this department with the San Diego Health Department, District Attorney, Police Department, Better Business Bureau, the U. S. Food and Drug Administration, a nurse, and a terminal cancer patient. At the appointed time and place, Dr. Ryan met with the cancer patient and made flamboyant promises to cure him with his ointment. He proffered a light-colored salve for internal cancer and a dark one for external malignancy, both to be applied to the skin.

A wire recording was made of Dr. Ryan's extravagant claims of previous cures, during an hour-long conversation with the patient which wound up with an offer of a "complete treatment" for $500. Upon receiving $300 in partial payment and in return dispensing a jar of salve, Dr. Ryan was arrested. Charges were brought against him of attempted grand theft and false advertising of drugs.

Analysis of the cancer salves showed their active ingredient to be croton oil, which is capable of blistering and burning the skin severely. Dr. Ryan, however, stated that the formula for his product was a family secret, and that the ingredient which did the curative work was one that "disappeared when added to the mixture."

Conviction by a jury in municipal court was for attempted grand theft.

Opinion Given on Admission Policy for County Hospitals

A recent opinion of the Attorney General's Office has created considerable interest in medical and hospital organizations. Opinion number 51/193 was written at the request of the district attorney of Merced County in answer to two questions: (1) May Merced County General Hospital maintain a policy of admitting all patients who are financially able to pay in full for their hospital care if the full cost of hospitalization is charged by the hospital? (2) As Merced County has received state and federal funds for the construction of hospital facilities under the provisions of the Hill-Burton Act, is it required that Merced County General Hospital admit patients who are financially able to pay for their care providing the facilities are avaliable for such care?

This opinion establishes that acceptance of Hill-Burton funds by a county institution does not obligate it to open its doors to pay patients. The factual situation as to the lack of hospital facilities in the community and not the receipt of state and federal funds is the determining factor in deciding whether the county hospital may be made available to paying patients. This opinion cites various legal decisions which establish that a county hospital is intended mainly to provide care for the indigent sick and dependent poor plus emergency treatment for pay patients, but where private hospital facilities are not sufficient to take care of patients with ability to pay for services it is permissible for the county hospital to accept private patients and to charge full rates for the services.

If after investigation a county board of supervisors determines that the facilities of the privately owned hospitals in the county are insufficient and that the health and general welfare of the citizens of that county require that the private hospital facilities be supplemented by making the county hospital available to the citizens of the county without regard to their ability to pay, the board is authorized to make the county hospital facilities so available.

County hospitals are not, however, legally open to full-pay patients except under these conditions. It is not their purpose to compete with private facilities, but rather to augment those facilities and to fill a gap unprovided for by those facilities. They operate in a governmental, not a proprietary, capacity.

Long Beach Nursing Vacancies

The Long Beach Department of Public Health has several vacancies for public health nurses. Salary range is $288 to $352. Applicants must possess a California Public Health Nursing Certificate and will be expected to establish residence in Long Beach if accepted for employment. Public Health nurses interested in the positions may write to the Long Beach Department of Public Health, 2655 Pine Avenue, Long Beach 6, indicating their qualifications for the position.

Among those on hand for the presentation ceremonies were (left to right): Stanley Lawson, President of the Monterey County Tuberculosis and Health Association from 1946 to 1950; Dr. Edward Kupka, Chief, Bureau of Tuberculosis Control, State Department of Public Health; Dr. John Sharp, Director of Monterey County's tuberculosis sanitorium; Helena Tavernetti, Executive Secretary of the Tuberculosis and Health Association; and Fred Farr, president of the association since 1950.

New Mobile Chest X-ray Unit Presented to Monterey

The Monterey County Tuberculosis and Health Association has presented a new mobile chest X-ray unit to Monterey County for use by the local health department. Keys to the new unit were accepted by the Chairman of the Board of Supervisors and turned over to Dr. Kenneth C. Sheriff, Director of the Health Department, in a public ceremony in February.

The unit, costing about $23,000 and purchased through the sale of Christmas Seals, uses up-to-the-minute Picker X-ray equipment. This machine will take 240 miniature films (70 mm.) per hour, and is also equipped to take 14 x 17 follow-up films. Films will be developed in a darkroom at the Monterey Health Department, and will be read by two local roentgenologists.

The unit has been dedicated to the memory of Ralph Hughes, who was treasurer of the Monterey Tuberculosis and Health Association during the years when most of the necessary funds were raised. Preceding the public ceremonies, a luncheon was held to honor the association's board of directors and individuals throughout the county who were instrumental in making the unit possible.

Dental Health Services in Schools Upheld by Attorney General

Legal authority of school districts to provide sch health services has been upheld by the Attorney G eral. The current question arose as to whether dental health program now being conducted in Sa Clara County is legal. The program includes the op ation of a traveling dental trailer which goes fr school to school. The dental trailer is operated by dentist who examines the school children's teeth, so times doing minor repair work, and referring oth matters to local dentists.

Basis for the reaffirmation rests in an opinion m in 1921 which discussed that question under state st utes then in existence. The Attorney General has re iterated that opinion (No. 4230) on several occasio since that time. The original statute relating to pro sion of school health services was adopted in 1909, a was superseded by a later act of 1919. In his opini of 1921 the Attorney General cites the latter act authorizing "the school trustees or the city or city a county board of education to make such rules for th examination of the pupils as will insure proper ca of the pupils and proper secrecy in connection wi any defect noted by the physical inspector, and su rules as may tend to correction of such physical defe or defects."

In answer to the current question, the Attorney Ge eral declares that the effect of sections added o amended to the original statutes have enlarged rath than decreased the authority of governing school board to provide school health services. These provisions ar now found in Sections 16401-16483 of the Educatio Code. Section 16441 provides, among other things, tha the governing board of the school district may appoin a supervisor of health, or supervisors of health, includ ing dentists. Section 16425 provides that the governin school boards may contract with their local health de partment for the necessary services to carry out th duties imposed by the sections of the Education Code.

The primary responsibility for health protection rests upon an alert and informed public.—*National Health Council.*

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